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ABSTRACT

A national survey of 474 community residential facilities for the adult mentally retarded focused on obtaining information on type of facility, source of referrals, development, resident population, and major problems. It was found that over 75% of the facilities have been in existence 5 years or less, that approximately half were private non-profit operations, that about half of the residents were between 16 and 30 years of age, that 60% of residents were males, that more than half had previously resided in an institution, that institutions had referred 42% of the placements, that 54% of the facilities received at least one supportive service from state residential institutions, and that 69% of residents functioned in regular or sheltered employment. Facilities reported their three most important problems to be inadequate funds, difficulty of finding qualified staff, and the development of individualized client programming. Motivating forces affecting the opening of the community residential facilities commonly included personal interest, influence of parents and/or other citizens, and encouragement of sheltered workshops or training centers. A second phase of the study will study the interrelationships among facilities, staff, residents, styles of resident life, services and programs, financial operations, and community relationships in the development and maintenance of the community residences. (DB)

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THE STUDY OF A NEW FRONTIER IN COMMUNITY SERVICES: RESIDENTIAL FACILITIES FOR DEVELOPMENTALLY DISABLED PERSONS

Gail O'Connor and E. George Sitkei

December, 1973

THE STUDY OF A NEW FRONTIER IN COMMUNITY SERVICES: RESIDENTIAL FACILITIES FOR DEVELOPMENTALLY DISABLED PERSONS

INTERIM REPORT

by

Gail O'Connor and E. George Sitkei
University of Oregon

INTRODUCTION

For too many years attention to mentally retarded persons has been focused on hiding them from society. This has led to many of the abuses and cases of neglect that have been publicized and brought to light in recent court actions (people vs. Partlow and the State of Alabama) on behalf of mentally retarded and other handicapped persons. Presently it is estimated that there are close to 200,000 mentally retarded and handicapped individuals residing in institutions in the United States and of this number a sizeable proportion (82%) are functioning below the educable or mildly retarded level of intelligence (Klaber, 1969). Historically, nearly all severely retarded and multipli-handicapped persons have life-long dependency and for them some form of publicly supported residential care becomes necessary if their parents die or are unable to care for them at home. Indeed, the probability is extremely high that anyone with an IQ of 50 or less will need some form of residential care during a portion or all of his life (Eyman, O'Connor, Tarjan, and Justice, 1972).

Moreover, the life expectancy of moderately and severely retarded individuals is greater than it was a few years ago (Tarjan, Eyman, and Miller, 1969). As these statements suggest, a very substantial proportion of retarded persons are in institutional facilities today and some sheltered residential care will undoubtedly remain an essential part of the service for the developmentally disabled. "In view of the high and increasing cost of residential provision, if for no other reason, great attention must be paid to residential services" (Tizard, 1970, p. 294).

NEW TRENDS

The current zeitgeist of changing services for retarded persons is reflected in the emphases placed on the "normalization principle" by the President's Committee on Mental Retardation in 1969. Bengt Nirje (1970) defined normalization as "making available tc the mentally subnormal patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society" (p. 62). Wolfensberger (1972) recently refined the definition as follows: "Utilization of means which are as culturally normative as possible in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible" (p. 28).

Concerned professionals, recent court cases and presidential directives have provided the impetus for a discernible national trend toward the development of community residential placements for developmentally disabled persons (Kugel, 1969; Wolfensberger, 1971). It is expected that increased emphases on the development of special living arrangements will provide the opportunity to place back in the community literally thousands of individuals who have hitherto been confined to institutions. The provision of an alternative prior to institutionalization will mean that in the future many individuals will not have to undergo the experience or stigma of having been institutionalized (Blatt, 1966; Edgerton, 1967; Goffman, 1957, 1961).

This trend can be expected to continue not only as a result of direct action by concerned professionals, but also because of the beginning of a new national attitude toward the rights of retarded citizens (Washington Post, 1972). It has long been recognized that institutions can range from humane treatment centers (Tizard, 1970) to warehouses of residents vegetating in giant institutions (Time, 1972). However, such environments as found at Willowbrook State School, New York, and Partlow State School, Alabama have given new impetus to a "bill of rights for the mentally retarded ... which will enforce a commitment to a minimal standard of decency" (New York Times, 1972). Indeed, the recent order by a Federal court in Alabama has resulted in the development of minimum institutional standards, three of which are of particular interest here. The first is the right of each resident to a "...habilitation program which will maximize his human abilities and enhance his ability to cope with his environment...;" the second is that "no mentally retarded persons shall be admitted to the institution if services and programs in the community can afford adequate habilitation;" and third, "...the right to the least restrictive conditions necessary..." (Wyatt vs. Stickney, et al., 1972).

CHANGING PHILOSOPHIES

It should also be noted that the larger institutions are not the only target of concern over unequal rights, but community educational systems across the country have also been under attack for denial of education to handicapped children. Two such recent cases involved the Commonwealth of Pennsylvania and the District of Columbia (The Wall Street Journal, 1972). Every indication is that such concern should and will continue to increase. In the face of the potential for tremendous expansion in community placements, every effort must be expended to assure that such programs not only meet minimal standards, but provide the opportunity for normalization of the life experience of developmentally disabled persons.

As literature is reviewed it becomes quite apparent that programs referred to as alternative community placements have covered very different types of services. To give some idea, these programs range from previously institutionalized individuals residing with their own parents or relatives, foster family care, and community residential facilities (sometimes known as group homes, half-way houses, hostels, etc.), to large

nurseries, nursing homes and convalescent hospitals. It is recognized that any of these residential placements could provide the opportunity for concomitant educational, work and recreational experiences. Nevertheless, it would appear that family life, both real and foster, and small groups of individuals living in a home-like residence in the community have the greatest potential for providing life experiences in line with the concept of normalization for developmentally disabled individuals who have the potential for some degree of independence without the constant provision of skilled nursing care.

One of the major difficulties in maximizing the habilitation and social functioning of developmentally disabled persons was the lack of suitable "special" living arrangements and integrated community services. This has resulted in many developmentally disabled individuals who are capable of going to school, working, enjoying recreation and other activities in normal environments to instead reside inappropriately in institutions or at home beyond their childhood years. Although some states have utilized community residential facilities for their mentally retarded population, it has been estimated that less than one percent of the national need for such facilities is being met.

Even though needs and resources do vary from state to state and community to community, it is expected that guidelines could be developed for the establishment and maintenance of community residences for developmentally disabled persons. Pertinent data about their existence and functioning should also be made available, and would serve as a basis for policy decisions at the national level to stimulate agencies and/or groups of individuals to undertake the establishment of more facilities across the country.

It is apparent that a variety of types of information is needed for enlightened decision-making regarding the optimal utilization of these alternative forms of care. Over the years many studies have been conducted focusing on real parents (Justice, O'Connor, and Warren, 1971) and to a lesser extent foster family care (Justice, O'Connor, and Bradley, 1969; Justice, Bradley, and O'Connor, 1971). In contrast to this there have been no comprehensive research studies in the area of group homes or community residences, and the available literature (at least in English) is heavily programmatic in nature (Bank-Mikkelson, 1968; Dybwad, 1969; Nirje, 1969; Wolfensberger, 1972; Sigelman, 1973).

METHODOLOGY

Procedure

In response to the need for intensive research in this field the Rehabilitation Research and Training Center in Mental Retardation at the University of Oregon was awarded a grant from SRS to study community residential facilities existing throughout the nation for the care of developmentally disabled persons. For the purposes of this project, "a community residence for developmentally disabled persons was defined as any community based residential facility which operates 24 hours a day

to provide services to a small group of mentally retarded and/or otherwise developmentally disabled persons who are presently or potentially capable of functioning in the community with some degree of independence. These living facilities may also be known as group homes, hostels, boarding houses, and halfway houses. However, this definition does not include foster family placement typically serving five or fewer developmentally disabled individuals. Nor does it include nursing home services or other forms of care which are primarily directed toward meeting the health or health related and/or medical needs of the resident."

The study involves two major phases, the main objective of the first phase was to identify the population of community residences and to obtain basic information from each regarding its facilities, source of referrals, development, resident population, and major problems. Some of this preliminary information will be used to select a smaller but representative sample of the population to participate in an indepth field study. As a result of this second phase, many of the interrelationships between facilities, staff, residents, styles of resident life, services and programs, financial operations, community relationships, and major problems encountered in developing and maintaining these residences can be studied.

The focus of this report is to provide an initial profile of these facilities and their residents. It is based on preliminary findings of the first phase of the study, that is, the operators' responses to the nationwide mail survey of identified facilities.

Development of the Facility Registry

The initial step in locating facilities involved contacting 50 coordinators of state programs for the mentally retarded and 209 superintendents of public residential facilities for the mentally retarded. The request entailed their nomination of all facilities known to them which met the operational definition. Requests for information were also sent to members of the State Developmental Disabilities Councils, representatives of State Associations for Retarded Children, and individuals identified by earlier contacts as potential sources of information. Follow-up by mail and by telephone was continued until the staff was satisfied that the required information had been obtained. A record keeping procedure for monitoring the location of these facilities has been maintained for internal project use such as providing information about various programs and services, and for sampling for the indepth interview follow-up study.

Implementation of the National Survey

The survey instrument referred to as the "Information Form," and a cover letter accompanying each was mailed to all facilities which were nominated by any of the sources described earlier. This resulted in a mailout to over 3,400 facilities. The staff realized that this figure was a vast overestimate of the number of such facilities; however, it

was decided that no facility would be excluded prior to data collection. Overestimation occurred because the nominators in some states screened the facilities in their state rather carefully according to our definition; whereas in other states lists of all placements were provided without discrimination.

The survey questionnaire was mailed, and those facilities not responding received two follow-up cards approximately three and six weeks after the questionnaires were sent. Further, a nationwide WATS line was installed for phone follow-up. This follow-up procedure made it possible to: (1) ascertain if the facility fit our definition, and if so, encourage their response; and (2) in the case of respondents with missing or inaccurate data it provided an opportunity for data "clean up."

As the returns were received, careful screening procedures, using three Ph.D. level staff members, determined the status of each questionnaire. Based on information sent by the respondents, on data from the questionnaire, and preliminary information from the nominators, a decision was made to include or omit a facility. Because of some unresolved answers from these sources, telephone follow-ups were used to clarify the status of some facilities. In this manner the final determinants for inclusion were based on much more valid information than could have been obtained prior to the mailing of the questionnaire forms.

Disposition of the Survey Forms

A decision was made to use August 1, 1973 as a cut-off date for determining the disposition of all surveys. A total of 3475 survey forms had been mailed and of this number 2495 (72 percent of the original list) were determined not to fit the criteria that had been established for a community residential facility either by inspection of the returned form or other means. About 14 percent of these determinations were made on the basis of telephone calls after receiving incomplete or inconsistent data on the survey form.

Initially 92 questionnaires were post office returns due to insufficient address, no forwarding address, etc. About a third of these were resolved through phone contact or a second mailing based on an updated address. The final count was 61 or about two percent for questionnaires that were non-deliverable by the post office.

The problem of calculating the number of unreturned forms was complicated by a number of factors. When no response was received after the second post card follow-up, phone contacts established that some questionnaires were lost and the respondent requested a second form. Often these also were not returned but then constituted another type of record keeping. When no phone was available, one more attempt was made to solicit a response by sending another questionnaire and a letter of appeal. This procedure brought in a few more returns, but still left a total of 322 non-respondents or about nine percent of the total. The non-returns in this category could probably be considered as implicit

refusals. However, a premise that may be valid is that the greater proportion of these operators did not consider their facility to meet our criteria and therefore had little interest or concern about returning the form.

A small proportion (less than one percent) gave a written or verbal statement to the effect that they did not wish to take part in the survey. A number cited reasons such as lack of time, too many surveys to complete, illness by respondent, and others. The total rate of refusal, whether explicit or implicit amounted to a little over 12 percent. Since the cutoff time of this report, questionnaires have continued to be received. A conservative estimate of the final rate of non-returns or refusals will probably be around 10 percent.

A total of 474 facilities have met the criteria for inclusion in this study. A number of these facilities also reported the existence of additional facilities owned or managed by the same operator. When this fact was known, an attempt was made to obtain basic information about them. In total, 112 additional facilities have been identified, but data about these is not included in this report. The original facilities, plus the 112 additional facilities will constitute the population from which a proportional sample will be drawn for further in-depth study during the next phase of the research project.

FINDINGS OF THE NATIONAL SURVEY

The trend in the development of the currently existing facilities is evident in Figure 1. A dramatic increase in facilities has occurred since 1968, in that over 75% have been in existence 5 years or less and 46% within the past two years. Three quarters of these facilities serve developmentally disabled only, whereas one quarter serve other disabilities as well.

FIGURE 1

Community Residential Facilities in Operation by Year Since 1950

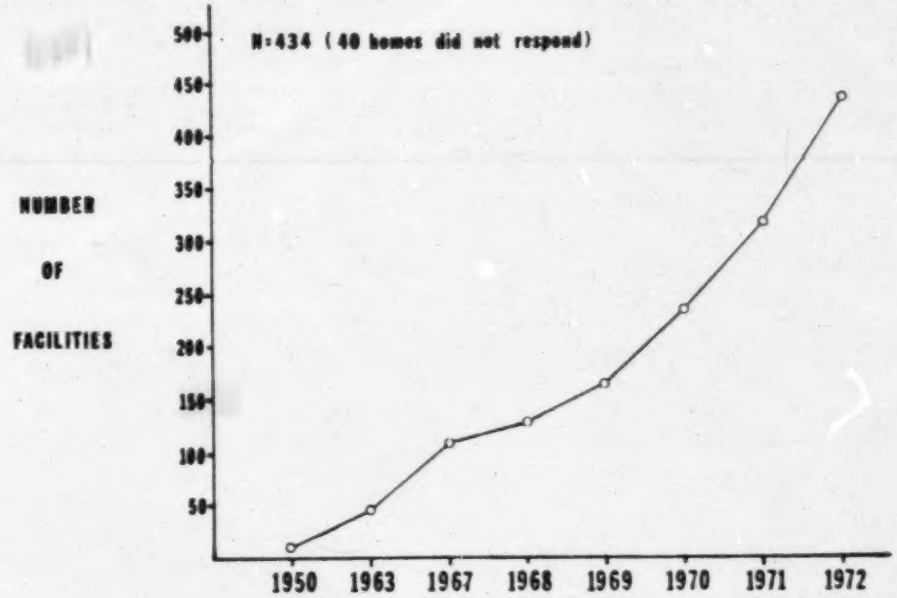


FIGURE 2

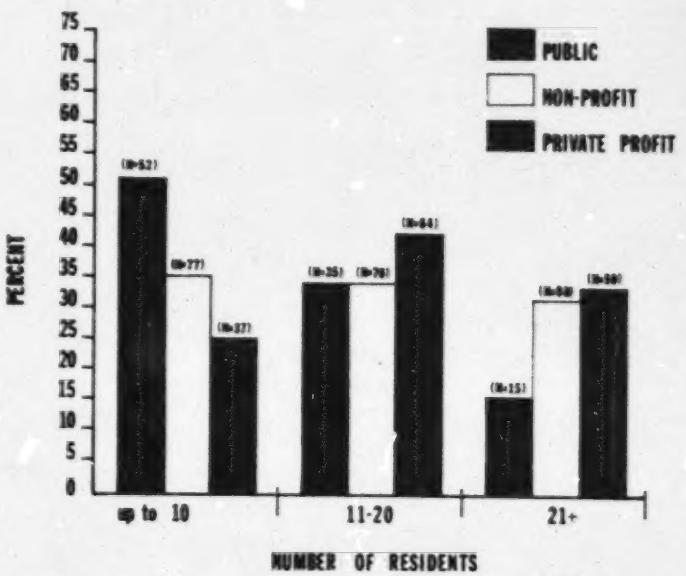
Map of the United States Showing Percent of Community Residential Facilities by H.E.W. Region

The establishment of community residential facilities by Health, Education and Welfare Regions is shown in Figure 2. Region V with states around and near the Great Lakes maintains the largest number of facilities with 23 percent of the total. The Northwest, Region X, ranks second with 12 percent. Three regions tied for third rank with 10 percent each, Regions II, VII, and IX.

There are three basic types of facility organizations: public, private non-profit and private profit. Of the total of 474 facilities surveyed, it was found that almost one-half (47 percent) were non-profit, privately run operations while the second largest category (32 percent) was the private profit-making facility. The public operated agency had the smallest number (22 percent) of facilities in operation. The relationship between these types and the number of residents they serve is shown in Figure 3. Public facilities tend to have the fewest number of residents and tend to use smaller facilities while private profit facilities appear to be slightly larger than the non-profit or public facilities.

FIGURE 3

Size of Facility by Percent Compared
to Type of Facility Organization



Residents were grouped by ages into three categories, age 20 and under, 21 to 30 years, and those 31 years and older. In Figure 4 these groupings were represented by percentages for each of the three types of facility organization. The public facilities catered to the younger population while the greatest number of facilities with older residents were found in the private profit organization. Non-profit organizations tended to pattern after the public, but had a slightly higher percentage of facilities with the young adult population.

FIGURE 4

Age of Residents by Percent Compared
to Type of Facility Organization

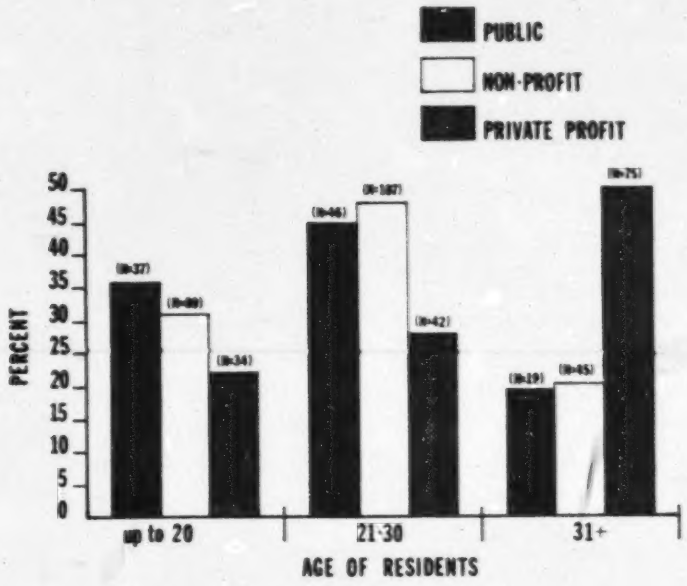
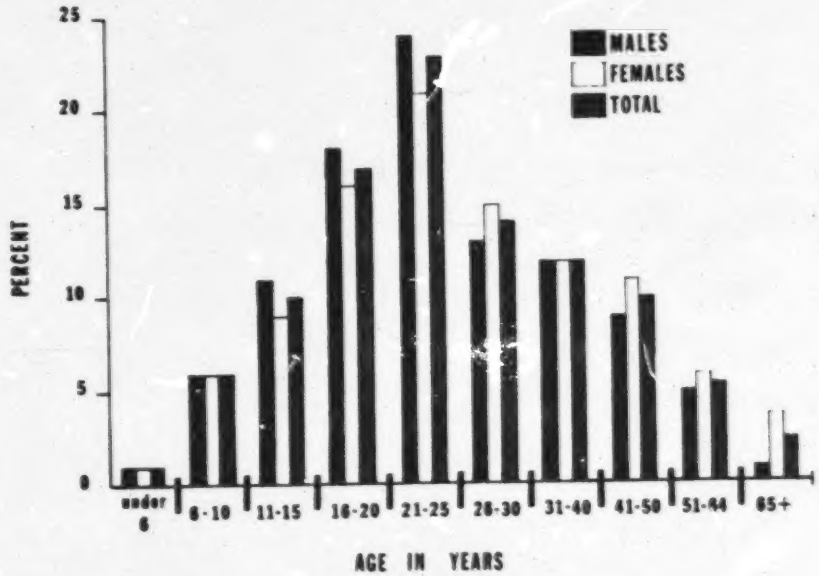


FIGURE 5

Age Distribution in Percent Compared
by Male vs Female and for Total

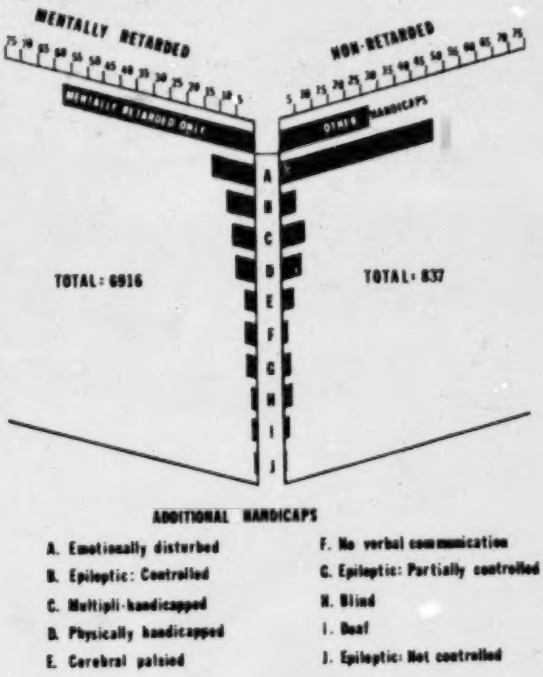


Looking now at the characteristics of the individual residing in these facilities Figure 5 combines the age and sex distribution. As can be seen, approximately one-half of the residents are between 16 and 30 years of age, the key age span for moving into more independent living arrangements and participation in a working environment. Not surprisingly, the sex distribution is a 60-40 percent split, with males in the greater proportion.

Information regarding the disabilities of individuals residing in these homes is shown in Figure 6. The vast majority (89%) is mentally retarded, only one percent are non-retarded but otherwise developmentally disabled, and ten percent are non-retarded but have other problems, primarily emotional disturbance. The additional handicaps of both the retarded and non-retarded are shown by letter coding on this graph.

FIGURE 6

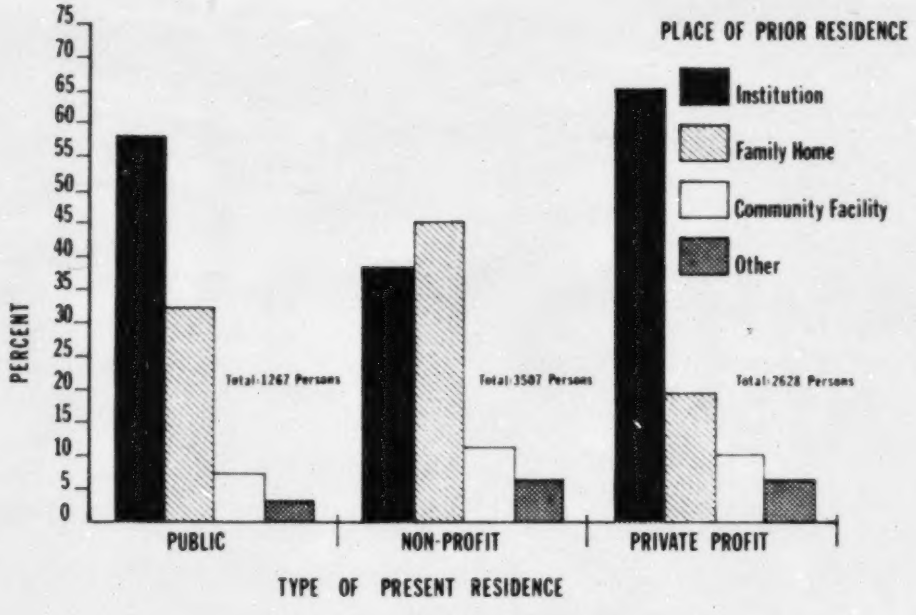
Disability Categories for Retarded and Non-Retarded Residents



Information regarding the previous place of residence for the clients provided some interesting data for comparative purposes. With over 98 percent of all residents accounted for in this tally, it was found that over one-half had resided in an institution, while about one-third had moved directly from their own home. A foster home or other community residential facility was the prior residence for about ten percent of this population. From Figure 7 it can be seen that profit and public facilities receive the bulk of their residents from institutions while the non-profit seem to have slightly more from the family home than from an institution. Transfers from other community facilities (including foster homes) appear to be distributed about equally among the three types of management organizations.

FIGURE 7

Place of Prior Residence Compared to
Present Placement in Community Residences



The source of referral to the community facility was known for about 93 percent of all residents. In this sample it was reported that an institution had made 42 percent of the placements and that a clinic or social agency was responsible for 29 percent of the referrals. A total of 18 percent of the residents had been placed by recommendations of family or friends, with the balance of five percent reflected in the category "other." The remaining six percent were marked as a "don't know" response.

In addition to knowing the prior residence of the clients, information was solicited about the movement out, or mobility of population. Using a base population of 7753 per year in the facilities studied, it was found that 3073 (40 percent) had made some type of change in their residence during the past year. Of those who had moved, over one-third were now living independently in the community. Slightly less than one-fourth had returned to their family home while one-sixth had transferred to another community residence. About one in seven moved to an institution but it was not possible to determine how many individuals of this group had originally resided in an institution and were returning. A small number (five percent) were known to have moved but respondents were not aware of the destination of this group.

Almost 60 percent of the operators have a formal arrangement with the state residential institution for placement into their facility. In these residences, as well as those with no formal arrangements, a variety

of supportive services are still provided by the state institution. These services, as shown in Table 1, are used in different combinations by various facilities. Of these the most common are diagnosis and evaluation, medical services and personal counseling.

TABLE 1

Number and Percent of Facilities Receiving Supportive Services From State Residential Institutions

Type of Supportive Services	Number of Facilities	%[a]
Receives at least one supportive service	257	54
Medical service	160	34
Diagnostic and evaluation	149	31
Vocational training	84	18
Educational service	67	14
Personal counseling	138	29
Social and Recreational programs	97	20
Other	17	4

[a]% based on N receiving service divided by the total number of facilities (N = 474)

Research has shown that individuals with the same level of measured intelligence may still differ widely in patterns of ability and in a variety of social adaptations. In many cases mental retardation may co-exist with other handicaps, and for this reason classification on a single global score, such as I.Q., is not appropriate. Since there is a positive correlation between intelligence and a person's adaptive behavior, it was decided that a scale to measure present behavior adaptation to the environment would be somewhat easier for operators to understand and use. In the present circumstances respondents were asked to make a judgment concerning the level of functioning for residents sixteen years of age and over.

Using five categories of adaptive behavior ranging from the highest level, seeking and successfully holding a job, to the lowest category, the need for complete care and supervision, the number of persons matching the descriptive categories was elicited. The scale, as developed by Heber (1961) was modified for use in this project and is shown in Appendix A of this report. The tabulations on this question are based on a total of 6,428 residents representing 83 percent of the total population. In Table 2 the number and percent of residents in each level are presented.

TABLE 2

Distribution by Number and Percent of Residents in Each Level of the Adaptive Behavior Scale (16 years +)

Level of Adaptive Behavior	N	%
Seeks and holds competitive job	461	7
Able to hold a full-time job	1210	19
Functions in semi or unskilled jobs	2748	43
Some self support with supervision	1400	22
Complete care and supervision	609	9
Total	6428	

The extent to which the total group of residents are involved in normalizing activities in their community is also of primary concern. The areas of school and work are presented in Table 3 where it can be seen that 62 percent of those individuals 20 years of age or younger are in community school programs. As these findings are based on grouped data, the denominator for work oriented activities was set as 21 years and older; of that group one-fourth are in regular jobs, one-fourth in long term sheltered employment, one-fourth in activity centers, and 40 percent are receiving vocational training. Since individuals may participate in more than one activity, the total for the percentage column does equal more than 100 percent.

TABLE 3

Resident Participation in School and Work Related Activities

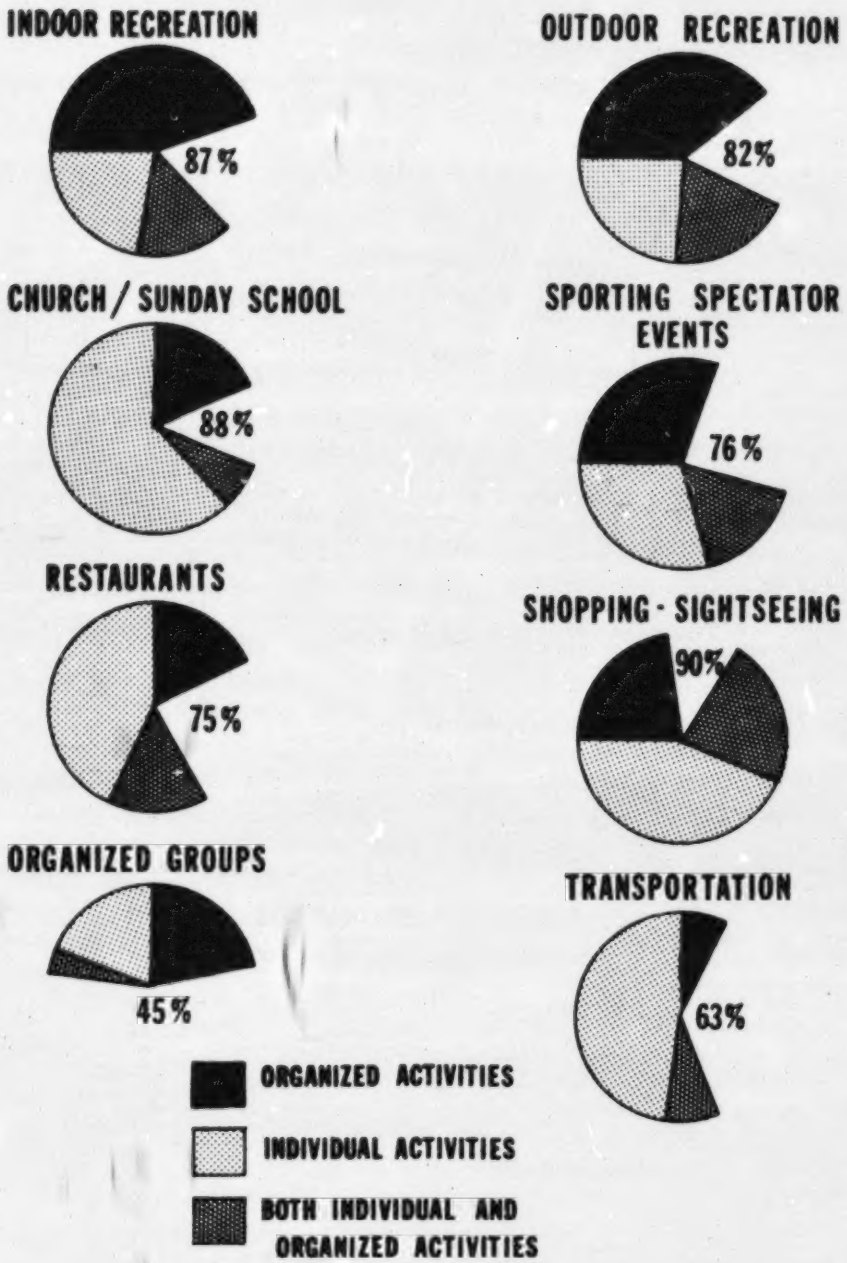
Type of Activity	N	%
Public school education	1650	62[a]
Regular job in the community	1321	26[b]
Vocation training	2043	40[b]
Long-term sheltered employment	1269	25[b]
Activity center	1249	25[b]
Adult education	122	2[b]
Other	189	2[c]

[a]This percentage was based on the number reported in these programs by the number of individuals $\leq$ 20 years of age (N = 2671)
[b]These percentages were based on the number reported in the program by the number of individuals $\geq$ 21 years of age (N = 5082)
[c]This percentage was based on the total residents (N = 7753)

High reporting percentages were found for ongoing socio-recreational activities of residents, as shown in Figure 8. For example, in the total column 90 percent of the respondents reported participation in "shopping-sightseeing" as an organized, individual, or combination activity for their facility. Similarily, percentages in the high eighties were found for indoor recreation and church/Sunday school activities. The only activity falling below the 50th percentile for the total group had to do with activities sponsored by organized groups such as the YMCA, Scouts, etc. The relatively high percentage (48) for independent use of transportation by individuals was a finding that was not expected.

FIGURE 8

Number and Percent of Facilities Reporting Ongoing Socio-Recreational Activities of Residents



Respondents were asked to identify the three most serious problem areas in establishing and operating their facility. As can be seen in Table 4 inadequate funding was reported to be the 1st, 2nd, or 3rd most serious problem by 62 percent of all homes, with 49 percent reporting it as the most serious problem. The second most serious problem reported by almost 40 percent of the homes was finding qualified staff. The development of individualized client programming was the third most important problem.

TABLE 4

Ranking of Most Serious Problem Areas in Establishing and Operating Facilities

Areas of Concern	Total N	%[a]
Inadequate funds	294	62
Difficulty of finding qualified staff	174	37
Developing individualized client programming	135	29
Lack of community supportive services	113	24
Certification and/or licensing	95	20
Attitude of community toward residents	97	20
Staff training and development	88	19
Reducing parental fears	69	15
Difficulty of maintaining the staff	67	14
Zoning restrictions	56	12
Meeting fire regulations	49	10
Meeting building safety standards	29	6
Other	64	14

[a]Percent based on number of facilities reporting a given problem as its 1st, 2nd, or 3rd most important problem divided by total number of facilities (N = 474)

In an attempt to determine the motivating factors that are required to open a community facility, it was found that in many cases more than one factor was involved. A tabulation of the results of this question indicates that respondents had checked more than one choice and in a number of cases three and four choices were selected. One premise is that more than just a personal interest (the largest single choice) must be present in order to succeed in establishing a community residence and that often many forces are operating to bring about the necessary committments. A fairly even distribution of choices was obtained for five of the eight options presented, as seen in Table 5.

TABLE 5

Motivating Forces or Agencies Affecting the Opening of a Community Residential Facility

Motivating Force	N	%
Personal interest	237	50
Interested parents and/or other citizens	157	33
Local service clubs and organizations	33	7
Local MH/MR boards	89	19
Sheltered workshops/ training centers	98	21
State social welfare agencies or personnel	57	12
State residential facilities	83	18
Other	67	14

When asked about the type of community in which their facility was located, three-fourths of the respondents indicated a residential area. Slightly more than ten percent were located in some type of farm or rural area while only six percent resided in a commercial or industrial zone. The balance of approximately ten percent checked a category marked "other" and wrote in responses such as church property, school grounds, etc.

The type of housing in use showed considerable variation although over one-half had selected a previous private residence for their purposes. The number of facilities that had been a hotel, motel or apartment building was about fifteen percent of the total with about the same percentage having the use of a new facility that had been expressly designed for the developmentally disabled. A little less than twenty percent were categorized as "other" and included places that were now converted from former convents, hospitals, nursing homes, churches, etc.

Only 56 percent of the respondents completed the item requiring a numerical figure for their annual operating budget. The amounts specified ranged from $2,000 to $500,000 with a median of $40,000. Further analysis determined that the median annual cost per resident for this group of facilities was $2,981. This figure is based on the annual operating budget divided by the number of residents in the facility at the time of the survey. This figure is in line with the amount of approximately $250 per month as reported by several state agencies. Inspection of these

budgets and the number of residents tends to show a linear relationship, but there are exceptions where some smaller facilities are spending more per person than larger ones.

In many of these facilities there are multiple sources of funding. It was not possible for these respondents to accurately assess the relative amounts of federal-state contributions due to state administration of federal formula and block grants. However, slightly over one-half of the facilities reported some funds received from parents or residents, and 15 percent reported funds received from foundations, or as gifts.

Concerning their plans for change, respondents were questioned on the possibility of increasing or decreasing the size of staff, size of facility, number of residents, and plans for programs and activities. Totally, over 60 percent of the respondents indicated that some type of change was contemplated. Except for a negligible percent in the negative direction, the choice of change was mainly for an increase in each of these categories. An increase as large as 31 percent was contemplated for programs and activities while the increase in staff size and resident capacity were about equal with 24 percent. About 13 percent were contemplating an increase in the size of the facility. Of these, 30 percent were going to move to larger facilities in order to accomplish this. In a similar way, another group of about 33 percent were contemplating the opening of another facility in order to accommodate more residents. Of the total population under study, only five respondents indicated a choice to move to a smaller facility but closer inspection of their intentions indicates that two were intending to build apartment-type units and in fact would be increasing the number of residents served. Three had options to close the present facility and to open another one, presumably smaller in size. Fourteen facilities were planning to close the present facility, but of these, nine were only changing their mode of operation while five appeared to be actually planning to go out of business.

SUMMARY

A number of important implications can be drawn from the analysis of the first phase of this study. There is clear-cut evidence that the community residential facilities movement as an alternative to institutionalization is gaining momentum. A number of important issues have emerged as primary concerns of the operators namely, funding, staffing, and individual developmental plans for residents. These must be dealt with in order to assure continued success for these residential programs.

Further, it is apparent that these facilities do provide opportunities for residents of varying ages and disability categories to participate in school, work, recreational and other community activities. There is an awareness that participation in the community will require cooperation between operators, residents, and other citizens in order to accomplish positive results.

It is likely that the summarization of the results from this study may have an impact on reviewing new patterns of residential care and perhaps for the first time, of planning ways to make it possible for the field of mental retardation to beneficially affect the values, consciousness, and activities of the larger community. The benefits to the larger society can only be affected by the systematic exploration of alternative ways to provide the necessary services and facilities for those deemed to be developmentally disabled. For these persons needing some kind of care other than institutionalization, they would not be required to make a complete break with what was familiar to them, while the ones who are discharged from the larger facility would be able to find a suitable environment in the community that has foreseen their needs and provided for them in an adequate fashion.

APPENDIX A

Levels of Adaptive Behavior[a]

1. Seeks and is able to hold a job in the competitive job market. Easily makes satisfactory social contacts and maintains independence when major difficulties arise.

2. Can effectively hold down a full-time job in community. Can make satisfactory social contacts. Sometimes unable to cope with serious social or vocational/economic stress (example: antagonistic peers, loss of job).

3. Able to function in unskilled or semi-skilled jobs (sheltered workshops, etc.) Needs supervision and guidance if under mild social or economic stress (example: fighting, name-calling, loss of money).

4. Able to maintain some self-support activity under complete supervision. Has developed self-protection skills to a minimum useful level under a controlled environment.

5. Needs complete care and supervision. Has complete care and supervision. Has some motor task and speech developement. Minimal self-maintenance abilities.

[a]Adadpted from Heber (1961)

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